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Discrimination against Persons with Mental Disorders: The Importance of Legal Capacity

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2014

document version

Publisher's PDF, also known as Version of record

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citation for published version (APA)

Pathare, S. R. (2014). *Discrimination against Persons with Mental Disorders: The Importance of Legal Capacity: Studies from India*. [PhD-Thesis – Research external, graduation internal, Vrije Universiteit Amsterdam]. D G Copiers.

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Discrimination is an everyday occurrence for many people with mental disorders in all spheres of life. Discrimination leads to denial of opportunities to live a normal social life, exclusion from the community and abuse. Stigma and discrimination are inter-related and represent two facets of the same underlying phenomena. Stigma represents the negative attitudinal aspects associated with mental disorders, while discrimination represents its behaviour component. Discrimination can be addressed directly by legislative efforts (e.g. laws to prevent discrimination) and policy efforts (e.g. affirmative action).

Self-determination is fundamental to enable people to achieve their full potential. However legal systems across the world presume that persons with mental disorders are unable to act and manage their lives independently. The presumption of lack of capacity for self-determination and the consequent denial of legal capacity to persons with mental disorders is the fundamental discrimination which then leads to discrimination in other spheres of life. This thesis hopes to shed light on this important issue and suggest possible solutions for addressing discrimination faced by persons with mental disorders.

It is hypothesized that, Indian laws and their judicial interpretation systematically discriminate against persons with mental disorders through the denial of legal capacity and thus prevent their full and effective participation in society. These legal barriers go hand in hand with attitudinal barriers of mental health professionals towards persons with mental disorders.

Based on this hypothesis the overall research question guiding this thesis is as follows:

What are the legal barriers to implementing full citizenship rights for persons with mental disorders in India and what strategies and opportunities can be identified to move towards a more rights based system for persons with mental disorders in India?

Using a mixed methods design, this thesis attempts to answer the overall research question by breaking it down into the following sub-questions:

1. To what extent are persons with mental disorders treated as persons with rights in low and middle income countries?

Part I of the thesis brought together different sources of evidence from reports and publications in addition to experiences of 51 people with mental disorders from across low and middle income countries to provide a comprehensive picture of the human rights violations experienced by persons with mental disorders. The key finding from this study was discrimination led to pervasive human rights violations. Empowerment of users of mental health services was suggested by respondents as one of the strategies to address discrimination.

In many countries people with mental or psychosocial disabilities are deprived of their legal right to make decisions and the authority is handed to a third person, a guardian. Decisions concerning health care are also made by guardians, which can result in people being detained in mental health facilities and treated against their will. Despite the far-reaching powers that can be exercised by guardians, there are very often few or no judicial mechanisms to enable people to appeal their involuntary admission and treatment or protect their right to exercise their legal capacity more generally.

The denial of legal capacity can also mean that a person is excluded from participation in social and political life, such as the right to vote or be elected, and to participate in the development and implementation of laws and policies that concern them.

To promote empowerment at the individual level, efforts need to focus on ensuring that people with mental and psychosocial disabilities are able to exercise their legal capacity in line with article 12 of the CRPD. Law and policy reform was identified by respondents in the study as a key strategy to promote human rights.

2. Does the content of mental health laws discriminate against people with mental disorders and if so, how?

Part II of this thesis reviewed the content of mental health legislation across Commonwealth countries (including India). The review showed that substantive and procedural provisions related to guardianship in mental health laws are problematic and deny legal capacity to persons with mental disorders.

Mental health legislation in only four Commonwealth member states had provisions for supported decision making including the provision of Advance Directives in their mental health legislation. 24 (53 per cent) Commonwealth countries had provisions for guardianship in their mental health laws. 7 countries only allowed limited guardianship usually restricted to property matters, while the majority (58 per cent) of mental health laws had provisions for both limited and plenary guardianship. This provision of plenary guardianship is almost certainly in conflict with the countries' obligations under Article 12 of the CRPD.

There were also procedural issues with guardianship in Commonwealth countries. Only 3 country laws required that the person who is the subject of guardianship should be present at or represented at the guardianship hearing. Majority of the country laws (66%) had no provision for appeal against the guardianship ruling and 79% of the laws did not have any provisions for regular time bound review of the guardianship decisions. The lack of these procedural protections is contrary to the requirements of Article 13(1) of the CRPD.

3. Does the practice of law in India discriminate against people with mental disorders and if so, how?

Part III of this thesis analysed court cases which were filed for divorce or annulment at the Family Court in Pune, India, where one of the parties had pleaded mental disorder in the spouse as grounds for divorce/annulment. A large majority of these petitions were filed by husbands alleging mental disorder in their wives, suggesting that women with mental disorders are particularly vulnerable to discriminatory practices. In nearly a quarter of the cases, divorce or nullity was granted even when no medical evidence to substantiate an allegation of mental disorder in the spouse was presented in Court. Even in cases where medical evidence was presented, it was often of poor quality.

At the Family Court level, 85% of cases filed were by husbands alleging mental illness in their wives. Similarly, of the cases that reached the High Court level, male petitions had filed 95% of the petitions originally at the Family Court. This suggest that men rather than women are using mental illness in their spouse as a grounds for divorce or nullity. This is possibly reflective of the differential social positions of men and women in Indian society.

We also found that medical evidence for mental illness was presented in only a third of the cases despite the fact that mental illness was pleaded as the basis for nullity or divorce. When no medical evidence was presented, divorce or nullity was still granted in 22% of instances, compared to (only) a 35% success rate of petitions when medical evidence of mental illness is presented. Even when medical evidence is presented, the results show that it was often of poor quality to be considered as robust proof of a mental illness.

4. What strategies can be employed at the legislative level and at the professional (judicial professionals and mental health professionals) level to prevent discrimination by recognizing legal capacity of persons with mental disorders?

Part IV of the thesis reviewed different models of supported decision making from around the world. Our findings indicated disconnect between international conventions (CRPD) and domestic legislation. We found very limited evidence on supported decision-making, and even less evidence on interventions assessing autonomy and decision-making outside treatment decisions.

This review showed that only a few countries have provisions for supported decision-making for persons with mental disorders, with a particular lack of such provisions in legislation in low and middle income countries (LMICs). We found no evidence of programs in LMICs to train health professionals in supported decision making. The question remains as to how supported decision-making models can be feasible for clinicians and clients, and adapted to suit the legal and medical context in LMICs.

Psychiatric Advance Directives (PAD) are one form of supported decision making which allows the person with mental disorder to retain control over her treatment even during periods of illness when there may be severe impairment of decisional capacity. A review of the literature showed that implementation of Advance Directives has been difficult globally due to barriers which can be clustered into system level barriers, health professional level barriers and service user level barriers. Potential strategies for overcoming these barriers include providing facilitators to help persons with mental disorders in writing Advance Directives, increasing awareness and training for mental health professionals on Advance Directives and supported decision making in general and the need for health information systems for storage and retrieval of Advance Directives.

Part IV of the thesis also included one qualitative study and one quantitative study to understand service user perspectives on Advance Directives in Tamil Nadu, India. Most clients and carers were unfamiliar with Psychiatric Advance Directives (PAD), and while some clients felt it is important to have a say in treatment wishes, carers expressed concerns about service user capacity to make decisions. After completing PAD, clients reported an increase in self-efficacy and an increased desire to make decisions. The quantitative study found that people with severe and persistent mental disorders can clearly specify treatment preferences and care in an Advance Directive and these PAD are feasible, useful and consistent with standards of care. Belying mental health professionals' fears that AD will be used to refuse treatment, no user in this study outright refused care in a PAD and very few disagreed with the idea of being taken to hospital if necessary or receiving treatment if necessary.

5. How can lessons learnt from the above inquiries be applied in practice?

The author was a technical consultant to the Ministry of Health and Family Welfare for drafting the new mental health law (MHC Bill) for India. The epilogue represents a reflection of the author's application of research findings in mental health and human rights to the MHC Bill as well as work as a member of the Policy Group.

The research findings presented in this thesis show that the legal system in India (laws and their practice) systematically discriminates against persons with mental disorders chiefly by denying the legal capacity of persons with mental disorders. As a first step, laws in India need to recognize the legal capacity of persons with mental disorders. Social model theory also requires that society make appropriate accommodation to enable persons with disability to take part in normal life in the community on an equal basis with others. Supported decision making for persons with mental disorders is an accommodation which allows persons with mental disorders to exercise legal capacity on an equal basis with others. Psychiatric Advance Directives (PAD) are one form of supported decision

making which can help persons with mental disorders exercise their legal capacity even during periods of illness when decision making may be impaired. Thus, a supported decision making paradigm enshrined in the law recognizes the 'personhood' of persons with mental disorders. This recognition of personhood is an important and crucial step in reducing discrimination against persons with mental disorders.

Along with changes to legislation there is also a need to address mental health professionals and legal professionals lack an understanding of legal capacity issues with respect to mental disorders and negative attitudes towards capacity of persons with mental disorders to make decisions. Training programmes for mental health professionals and legal professionals hold promise of bring about changes in knowledge and reducing negative attitudes.